



Texas Department of Insurance

Division of Workers' Compensation

Medical Fee Dispute Resolution, MS-48

7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645

512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

ALLIED MEDICAL CENTERS
PO BOX 24809
HOUSTON TEXAS 77029

DWC Claim #:
Injured Employee:
Date of Injury:
Employer Name:
Insurance Carrier #:

Respondent Name

ACIG INSURANCE CO

Carrier's Austin Representative

Box Number 47

MFDR Tracking Number

M4-11-3098-01

MFDR Date Received

May 12, 2011

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "TDI rule states that it is not enough for a carrier to file a TWCC denial code and that the carrier is required to submit claim specific language. Although the denial explanation is understandable it does not apply in this instance. The denial code and their description are too vague for our facility to determine the basis for the denial. This denial is not in compliance with Rule §133.3."

Amount in Dispute: \$121.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The date of service in question as submitted on form CMS-1500 with Carl C Davis, Jr, MD listed as the provider who rendered the service in box 31. On both the original submission and the subsequent reconsideration the provider billed for CPT code 99213 & 99080-73. Both the original audit and subsequent appeal were denied per rule 133.20(e) (2)..."

Response Submitted by: Corvel

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
December 13, 2010	99213, 99080-73	\$121.00	\$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §133.20 sets out the guidelines for medical bill submission by health care provider.

3. The services in dispute were reduced/denied by the respondent with the following reason codes:

Explanation of benefits

- B20 – Srvc partially/fully furnished by another provider
- 193 – Original payment decision maintained
- W3 – Additional payment on appeal/reconsideration

Issues

1. Did the insurance issue payment for CPT code 99080-73?
2. Did the requestor bill in conflict with Rule 133.20?
3. Is the requestor entitled to reimbursement?

Findings

1. Per 28 Texas Administrative Code §129.5 “(i) Notwithstanding any other provision of this title, a doctor may bill for, and a carrier shall reimburse, filing a complete Work Status Report required under this section or for providing a subsequent copy of a Work Status Report which was previously filed because the carrier, its agent, or the employer through its carrier, asks for an extra copy. The amount of reimbursement shall be \$15. A doctor shall not bill in excess of \$15 and shall not bill or be entitled to reimbursement for a Work Status Report which is not reimbursable under this section. Doctors are not required to submit a copy of the report being billed for with the bill if the report was previously provided. Doctors billing for Work Status Reports as permitted by this section shall do so as follows. (1) CPT code "99080" with modifier "73" shall be used when the doctor is billing for a report required under subsections (d)(1), (d)(2), and (f) of this section.”
 - Date of service, December 13, 2010, disputed CPT code 99080-73
 - Review of the submitted documentation in the form of an EOB dated April 22, 2011 supports that the insurance carrier issued payment for CPT code 99080-73, in the amount of \$15.00 as a result additional reimbursement cannot be recommended.
2. Per 28 Texas Administrative Code §133.20 (d) The health care provider that provided the health care shall submit its own bill, unless. (1) the health care was provided as part of a return to work rehabilitation program in accordance with the Division fee guidelines in effect for the dates of service; (2) the health care was provided by an unlicensed individual under the direct supervision of a licensed health care provider, in which case the supervising health care provider shall submit the bill; (3) the health care provider contracts with an agent for purposes of medical bill processing, in which case the health care provider agent may submit the bill; or (4) the health care provider is a pharmacy that has contracted with a pharmacy processing agent for purposes of medical bill processing, in which case the pharmacy processing agent may submit the bill.”
 - Date of service, December 13, 2010, disputed CPT code 99213
 - Review of the CMS-1500, box 31 requires the signature of physician or supplier, the requestor documents Carl C. Davis Jr., MD. Review of the Allied Medical Centers “Physical Medicine & rehabilitation Treatment Plan” does not contain a signature of the physician who rendered the services. The division is therefore unable to make a determination as to who rendered the disputed charge; as a result reimbursement cannot be recommended for CPT code 99213.
3. Review of the submitted documentation finds that the requestor is not entitled to reimbursement of the above noted charges.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is \$0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to \$0.00 reimbursement for the disputed services.

Authorized Signature

_____	_____	July 31, 2013
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision* together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party.****

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.